STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155278	A. BUILDING 00 B. WING	02/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-BLOOMINGTON	155 E BURKS DR BLOOMINGTON, IN 47401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for a Recertification and State Licensure Survey. This visit included the investigaiton of Complaint # IN00143745. Complaint # IN00143745-Substantiated. No deficiencies related to the allegations are sited. Survey dates: February 10, 11, 12, 13, & 14, 2014 Facility number: 000177 Provider number: 155278 AIM number: 100289860 Survey Team: Melissa Gillis, RN TC Cheryl Mabry, RN (2/13, 2/14, 2014) Diana McDonald, RN Angela Patterson, RN Census bed type: SNF/NF 128 Total: 128 Census payor type: Medicare: 9 Medicaid: 99 Other: 20 Total: 128	F000000	The submission of this Plan of Correction does not indicate an admission by Golden Living of Bloomington (the "Facility") that the findings and allegations contained herein are an accurate and true depiction of the quality of care and services provided to the patients of Golden Living of Bloomington. The Facility recognizes its obligation to provide legally and medically necessary care and services to its patients in an economic and efficient manner. The Facility hereby maintains it is in substantial compliance with the requirements of participation for Comprehensive Health Care Facilities (for Title 16/17 programs). To this end, this Plan of Correction shall service as the credible allegation of compliance with all state and federal requirement governing the management of this Facility. It is thus submitted as a matter of statute only.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Sample: 3 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality Review completed on February 23, 2014 , by Brenda Meredith R.N.			

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F000156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:			

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	A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits,			

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	and how to receive refunds for previous payments covered by such benefits. Based on interview and record review, the facility failed to ensure that residents were provided 48 hours notice before their Medicare coverage ran out. This affected 3 out of 3 residents looked at for Medicare Non-Coverage. (Resident #300, Resident #301, Resident #302) Findings include: On 2/14/14 at 1:30 p.m., the MDS Coordinator provided "Notice of Medicare Non-Coverage" for 3 residents, Resident #300, Resident #301, Resident #302. The forms were reviewed at this time. The form review for Resident #300 indicated the effective date coverage of current skilled nursing will end on 2/6/14. The record did not show the resident was contacted earlier than the day resident signed the form. The resident signed the form on signed 2/6/14. The form review for Resident #301 indicated the effective date coverage of current skilled nursing will end on 2/11/14. The record did not show the resident was contacted 48 hours	F000156	It shall be the policy of Golden Living (of Bloomington) to ensure all patients are advised of rights, rules, services, and charges as they may pertain to the regulations governing resident conduct and responsibilities during the stay in the Facility. Two of the patients discharged to home (from the Facility) on the same date the referenced form was signed. The RNAC was educated on the need to notify the patient and/or family 48 hours prior to the referenced services ending. The Facility will review all Medicare patients via the *Medicare Days Recap Summary* at the daily Facility startup meeting. All last covered days will be communicated for the initiation of non-coverage letters. .The RNAC will submit all notice of Medicare non-coverage letters to the DNS for review. The Business Office Manager will review/audit all "Denial" letters monthly. The QAPI Committee will review the audits monthly (x 6 months) to ensure compliance. The committee will recommend continued review or discontinuance.	03/16/2014

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	prior to services ending. The resident signed the form on 2/10/14. The form review for Resident #302 indicated the effective date coverage of current skilled nursing will end on 2/11/14. The record did not show the resident was contacted earlier than the day resident signed the form. The resident signed the form on 2/11/14. During an interview on 2/14/14 at 1:50 p.m., the MDS Coordinator provided the "Inner Circle: Key elements outlined for Medicare process," dated 2/23/04, and indicated this was what the facility followed and there were no other policies in place for notification of Medicare non-coverage. She also indicated they try to give the resident 48 hours notice, but it does not get done sometimes. 3.1-4(a)(3)			

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F000272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. Based on observation, record review and interview, the facility failed to ensure a resident was accurately assessed for 1 of 1 residents who were reviewed for dental status in	F000272	It shall be the policy of Golden Living (of Bloomington) to conduct comprehensive assessments (as required) to determine each patients functional capacity. Resident # 3	03/16/2014

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	the stage 2 sample. (Resident #3) Finding includes: On 2/13/2014 at 11:40 a.m., the clinical record was reviewed for Resident #3. Diagnosis included but were not limited to, hypertension, anemia, urinary tract infections, hyperpotassemia, chronic kidney disease stage IV, depressive disorder, gout, edema, diverticulosis of colon. The annual MDS (Minimum Data Set) dental assessment, completed on 8/27/2013, indicated no natural teeth or tooth fragments. No obvious or likely cavity or broken natural teeth. The quarterly MDS (Minimum Data Set) assessment, completed on 11/22/2013 indicated the BIMS (Brief Interview of the Mental Status) indicated Resident #3's score was an 11 out of a score of 0-15. This score indicated the resident was interviewable. Review of Resident #3's chart indicated there was no consult from Dentist in chart. The facilities "QUARTERLY		was seen by a Dentist on February 14, 2014. The exam revealed patient denying pain with tooth not causing discomfort and a recommendation to extract if needed. The patients son was notified and declined removal as it was not causing any problems. The Facility has entered into a new contractual agreement with a new dental provider (Prev-Med). The same has performed an initial assessment of all residents. An oral exam will be given to each patient annually. The Unit Managers will continue to complete a quarterly interdisciplinary review which includes an oral assessment. The Unit Managers will notify Social Services if a dental referral is required.	

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	INTERDISCIPLINARY RESIDENT REVIEW" completed on 2/5/14 at 2:50 p.m., for Resident #3 indicated.... "CONDITION OF TEETH/ORAL CAVITY....natural teeth, gum margins intact, mucous membrane moist...." There was no referral for dental consult documented on the "...Summary/Outcome/Recommend ations...." On 2/13/2014 at 2:45 p.m., an observation of Resident #3's mouth with LPN #2 indicated the tooth on the upper left in the back had a large metal filling, the tooth around the filling is broken. In the upper front Resident #3's to the right is broken off. At this time, LPN #2 asked Resident #3 if it was bothering her, Resident #3 indicated it hurts her tongue when her tongue touches it because it's broken off. 3.1-31(d)(3)			

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F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on interview and record review, the facility failed to develop a care plan to address urinary incontinence for 1 of 2 residents who were reviewed for urinary incontinence in the stage 2 sample. (Resident #44)	F000279	It shall be the policy of Golden Living (of Bloomington) to utilize the result of each patient assessment to develop, review, and update the patients comprehensive plan of care as required. A careplan was developed for patient #44 to address urinary incontinence.	03/16/2014

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	Finding includes: On 2/12/2014 the clinical record was reviewed for Resident #44. Diagnosis included but were not limited to, hypertension, weight loss, disorders of bone and cartilage, anxiety, chronic pain, dementia, atrial fibrillation. The MDS (Minimum Data Set) assessment, completed on 9-19-2013, indicated Resident #44's bowel and bladder function as frequently incontinent. The assessment indicated she had been on a bladder retraining program in the past. The MDS (Minimum Data Set) assessment, completed on 11/07/2013, indicated Resident #44's bowel and bladder assessment as frequently incontinent. The quarterly MDS (Minimum Data Set) assessment, completed on 12/19/2013, indicated Resident #44's bowel and bladder assessment indicated she was frequently incontinent. On 2/12/14 at 3:20 p.m., an interview with the unit manager		All patients who have urinary incontinence were reviewed to ensure a careplan is in place to address the same. The Unit Managers and RNAC were inserviced on the need to careplan urinary incontinence as required. The RNAC will ensure any patient identified by the quarterly or significant change MDS (with urinary incontinence) has an appropriate careplan addressing urinary incontinence. The ADNS will audit all new admissions (within 7 days of admission) to ensure incontinent patients have a requisite care plan in place. The ADNS will report audit finding to the QAPI Committee for review for six (6) months.	

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	indicated Resident #44 had not been on a toileting plan since her readmission on 9/12/2013. On 2/12/14 at 3:21 p.m., the unit manager provided Resident #44's care plan. It indicated there was no care plan for incontinence. On 2/12/14 at 3:30 p.m., an interview with the MDS (Minimum Data Set) director indicated the MDS for 9-19-2013, was in error when indicated Resident #44 was on a toileting program. On 2/13/14 at 9:39 a.m., the ADON (Assistant Director of Nursing) provided the facilities "Bowel and Bladder Record Tracking Tool," dated 4-24-2006 and March 2007, the tool indicated Resident #44 was on the bowel and bladder tool from 9/12/13-9/15/2013. The tool indicated, "This tool is to be used as part of the analysis for determining the residents bowel and bladder status and for setting up a toileting program". 3.1-35(a)			

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F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review the facility failed to ensure that manufactures instructions were being followed when a powder inhaler was administered to residents without having the residents rinse with water afterward as directed by the manufacturer. This deficient practice had the potential to affect 2 of 4 residents observed for medication administration on hall 1. (Resident #13, Resident #30) (LPN #3) Findings include: 1. On 2/14/14 at 8:44 a.m., observed LPN #3 was observed to enter Resident #30's room and hand Resident #30 the Advair diskus inhaler (for the treatment of asthma). LPN #3 was not observed to have Resident #30 rinse mouth with water after using the inhaler.	F000282	It shall be the policy of Golden Living (of Bloomington) to provide/arrange for the provision of services by a qualified person in conjunction with the written plan of care. LPN #3 was inserviced on the proper administration of an inhaler including the rinsing of the mouth after each administration. All licensed nurses will be inserviced (3/13/14) regarding proper inhaler administration including rinsing of the mouth. The DCE and Weekend RN Supervisor will audit inhaler administration 5x's/week (and weekend) for one (1) week, 4x's/week (and weekend) for one (1) week, 3x's/week (and weekend) for one (1) week. Instructions on the eMAR will be revised to include rinsing of mouth after each inhaler administration. The Unit Managers will ensure all current patients and new admissions inhalers have the requisite instructions included on the eMAR. All audits will be turned in to the DNS for review. The QAPI	03/16/2014

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	2. On 2/14/14 at 8:54 a.m., observed LPN #3 to enter Resident #13's room and administer Advair inhaler to Resident #13, without having the resident rinse mouth after administering that medication. On 2/14/14 at 11:16 a.m., interview with LPN#3 indicated, when asked how should Advair inhaler be administered " Inhale one puff and then rinse mouth with water and spit out." When asked if that was done for Resident #13 and Resident #30, LPN #3 indicated, "No, I did not." On 2/14/14 at 3:09 p.m., review of the facilities current procedure labeled " Oral Inhalation Administration " that was revised on November 2011, was received from the ADON (Assistant Director of Nursing) 2/14/14 indicated, " ... Q. For steroid inhalers, provide resident with cup of water and instruct him/her to rinse mouth and spit water back into cup." On 2/14/14 review of Advair diskus https://www.advair.com. Administration Guidelines) that was revised on 9/2011, indicated, "... 2 DOSAGE AND ADMINISTRATION ADVAIR DISKUS should be		Committee will review the audit monthly for 3 months to determine discontinuation or the need for further review.	

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	administered twice daily every day by the orally inhaled route only. After inhalation, the patient should rinse the mouth with water without swallowing." 3.1-35 (g)(1)			
F000315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on interview and record review, the facility failed to ensure that a residents functional status related to bladder control was maintained for 1 of 2 residents who were reviewed in the stage 2 sample for bladder function. (Resident #44) Finding includes:	F000315	It shall be the policy of Golden Living (of Bloomington) to insure that a patient who enters the Facility incontinent of bladder receives appropriate treatment and services to restore as much normal bladder function as possible. Patient #44 was placed on a toileting program. All patients who have urinary incontinence were reviewed and assessed for a toileting program.	03/16/2014

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 2/12/2014 the clinical record was reviewed for Resident #44. Diagnosis included but were not limited to, hypertension, weight loss, disorders of bone and cartilage, anxiety, chronic pain, dementia, atrial fibrillation. The MDS (Minimum Data Set) assessment, completed on 9-19-2013, indicated Resident #44's bowel and bladder function as frequently incontinent. The assessment indicated she had been on a bladder retraining program in the past. The quarterly MDS (Minimum Data Set) assessment, completed on 12/19/2013, indicated Resident #44's bowel and bladder assessment indicated she was frequently incontinent. On 2/12/14 at 3:20 p.m., an interview with the unit manager indicated Resident #44 had not been on a toileting plan since her readmission on 9/12/2013. On 2/12/14 at 3:21 p.m., the unit manager provided Resident #44's care plan. The care plan indicated there was no care plan for incontinence.		The same was initiated for all appropriate patients. The RNAC will develop a restorative toileting program for all patients who are identified as incontinent (on a quarterly or significant change MDS) and are able to participate in a toileting program. The ADNS will audit and ensure all patients identified as incontinent (per the initial MDS) and who can actively participate have a restorative toileting plan in place. The ADNS will report audit findings to the QAPI Committee monthly x 6 months to determine the need for further review or discontinuation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155278	A. BUILDING 00 B. WING	02/14/2014

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	On 2/12/14 at 3:30 p.m., an interview with the MDS (Minimum Data Set) director indicated the MDS for 9-19-2013, was in error when indicated Resident #44 was on a toileting program. 3.1-41(a)(2)			
F000323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure the resident was assessed after each fall for preventative factors and possible interventions to prevent falls for 1 of 6 residents reviewed for accidents in the stage 2 sample. (Resident #40) Finding includes: On 2/13/2014 at 3:00 p.m.,the clinical record was reviewed for	F000323	It shall be the policy of Golden Living (of Bloomington) to ensure that the patient environment remains free from accident hazards and that each patient receives adequate supervision. Patient #40 was assessed after each fall as evidenced by the "Verification of Investigation". A fall "Risk Evaluation" was completed after each fall including an assessment for gait and balance. All patients who sustain a fall will be assessed through the "Verification of	03/16/2014

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	Resident #40. The diagnosis included but were not limited to, cerebral embolism with cerebral infarction, hemolytic anemia, cognitive deficits due cerebrovascular disease, senile dementia, hypertension, encephalopathy,depressive disorder, psychosis. The MDS (Minimum Data Set) assessment, completed on 1/15/2014, assessed Resident #40 as requiring limited assistance of one person to ambulate in the room or hall. The care plan for falls initiated on 6/13/2013, indicated the goal was "Will have minimal injuries r/t [related to] falls. The interventions included but were not limited to, call light or personal items available and in easy reach or provide reacher, and footwear to prevent slipping. Both intervention were initiated on 6/13/2013. Resident #40 had 3 falls between 12/30/2013 and 1/30/2014. Review of the facilities fall investigation indicated: 1. The facilities "VERIFICATION OF INVESTIGATION," for Resident #40		Investigation" to determine the root cause of the fall as well as having a fall "Risk Assessment" completed. The specific intervention related to the root cause will be added to the POC and communicated to the direct care staff by inservicing. All licensed nurses will be inserviced on the completion of the "Verification of Investigation" with each fall. The Unit Manager will ensure the "Verification of Investigation" is completed and a fall risk assessment is completed. The ADNS will audit all falls to insure the "Verification of Investigation" and fall "Risk Assessment" is completed with each fall. The ADNS will report the audit findings to QAPI monthly x 3 to determine the need for continuation or discontinuation.	

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	indicated he fell in his bathroom on 1/30/2014 at 1:00 a.m. The detailed description of the fall indicated "Resident was standing in b/r [bathroom] getting ready to viod [sic], lost balance and fell backwards. No injury obtained. Residents statement indicated "he just lost his balance and fell backwards". "Immediate protection initiated was gripper socks placed on resident, Res [resident] reminded to use call light for assistance prior to ambulating...." Summary of investigative findings indicated....Resident didn't have appropriate footwear on; Poor safety awareness d/t [due to] cognitive deficits secondary to cerebrovascular disease:....HX [history] of falls. Non-skid socks placed on resident, Res [Resident] encouraged not to get up without gripper socks on and to use call light to obtain assist prior to ambulating...." 2. The facilities "VERIFICATION OF INVESTIGATION" for Resident #40 on 1/16/2014 at 4:00 a.m., indicated: "Staff overheard loud noise from Res [Residents] room, staff responded and witnessed Res			

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	losing his balance and had thrown his walker out towards door; Res fell backwards, staff unable to reach Res in time to prevent fall. Res landed on his left side, legs were bent and resident lowered his upper torso so he could lie on floor. Res did not hit head....Res c/o's pain to back and buttocks, sating [stating] they are "sore"....Resident states he "just lost his balance and fell." Immediate Protection initiated for fall was Returned to bed, Call light placed in hand and non-slip socks placed on resident. Insructed [sic] resident not to get up without calling for assistance...." 3. The facilities "VERIFICATION OF INVESTIGATION' for Resident #40 on 12/04/2014 at 6:00 p.m., indicated the "writer was in nurses station next to res room and heard a loud noise. Res noted to by lying on floor in Res room, on his back next to his dresser...." Assessment of Resident indicated Upon finding Res, Res unable to verbally respond to writer; Head tilted back, moaning: Pupils non responsive to light...Episode lasted about 1 minute. Res became responsive....Res states his back hurts a "little". No visible injury noted.			

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	Resident interview summary: Res unable to recall what happened to cause fall, "I was just going to the bathroom." Immediate Resident Protection initiated toileting plan so that staff will be there with him while he amb [ambulates] to bathroom. Bed put in low position so res will use call light for assistance when he needs to get up. Summary and outcome....Res will be seen by neurologist per Doctor order. On 2/14/2014 at 10:10 a.m., an interview with the ADON (Assistant Director of Nursing) and DON (Director of Nursing) indicated the Doctor had ordered for Resident #40 to see a neurologist after his fall on 12/04/2013. The DON indicated the neurologist who had been seeing Resident #40 didn't want to see him anymore. 3.1-45(a)(2)			

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F000329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on observation, interview and record review, the facility failed to ensure adequate monitoring of for the side effects of medications including antipsychotic and antianxiety medications. This had the potential to effect 3 out of 5 residents reviewed for unnecessary medications. (Resident #133, Resident #148, Resident #44) Findings include:	F000329	It shall be the policy of Golden Living (of Bloomington) to ensure adequate monitoring is conducted for the side effects of medications - including antipsychotics and antianxieties. Patient #148's careplan was updated to include monitoring for S/S of increased risk of suicide, cardiovascular and infections risks. Patient #133 and #44 was careplanned for anxiety. All patients identified as being on an antipsychotic or antianxiety medicaitons were reviewed to ensure a careplan was in place with specific side effect noted.	03/16/2014

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	1. Record review for Resident #148 was completed on 2/14/14 at 10:10 a.m. Medical Diagnoses for Resident #148 include but not limited to dementia, vitamin B12 deficiency anemia, depressive disorder, insomnia, loss of weight anxiety, anxiety state, anorexia. Resident #148 has a score for the Brief Interview for Mental Status of 07, a score of 00-07 indicates severe impairment. The record indicated Resident #148 received Seroquel (an antipsychotic medication) 12.5 mg (milligrams) by mouth two times a day related to Dementia, with behavioral disturbance. Review of Resident #148's care plans indicated a plan of care for adverse drug reaction the interventions failed to include monitoring for signs and symptoms of increased risk of suicide, cardiovascular or infectious events. Review of the "2014 Lippincott's Nursing Drug Guide," "Black box warning: Increased Mortality in Elderly Patients with Dementia-Related Psychosis Elderly patients with dementia-related		The RNAC will ensure that all patients on an antipsychotic or antianxiety medication has a careplan in place. All patients on an antipsychotic medication will have side effects monitored every six (6) months by the completion of the "Discus" Form and quarterly interdisciplinary review. All licensed Nurses will be inserviced on the side effects of antipsychotic and antianxiety medications. Any S/S will be documented in the progress notes and reported to the MD and/or Psychiatric Nurse Practitioner. Social Services will be notified for Behavior Committee Review. The Behavior Committee will review patients in the monthly Committee meeting which includes the Pharmacist and Psychiatric Nurse Practitioner. Behavior Committee findings will be reported to QAPI monthly by the Social Services Director x six (6) months. The QAPI Committee will determine the need for further review or continuation.	

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	psychosis treated with antipsychotic drugs are at an increased risk of death. Seroquel is not approved for the treatment of patients with dementia-related psychosis. Not approved for dementia-related psychosis; increase. mortality risk in elderly dementia patients on conventional or atypical antipsychotics; most deaths due to cardiovascular or infectious events...." 2. The clinical record for Resident #133 was reviewed on 2/12/2014 at 2:41 p.m. Diagnoses included, but not limited to, Alzheimer's, urinary tract infection, open fracture, depressive disorder, dementia with behavioral disturbances. The most recent quarterly Minimum Data Set (MDS) assessment,dated 12/6/2013, indicated Brief Interview for Mental Status (BIMS) is 8, where 8-15 was interviewable. Record review indicated Resident # 133 had orders for Ativan (antianxiety medication)1 mg (milligram) two times a day. Interview with DON on 2/13/14 at			

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	10:50 indicated there were no other care plans in place for anxiety medications. On 2/13/2014 at 1:50 p.m., an interview with LPN #1 (Licensed Practical Nurse) indicated that she does monitor for side effects like lethargy or sedation, but there is no where to document that there are no signs or symptoms for use of Ativan. The electronic medication administration (EMAR) record had no side effects listed for antidepressant or antianxiety medication. There was no sign off for signs or symptoms for use of an antianxiety medication. The facilities current policy "Behavior Management Guideline" dated 2013, indicated..."Other known side effects of these drugs that must be monitored include:..Monitoring Compliance IPOC or care plan is developed for residents exhibiting negative behavior or with anti psychotic drug uses. A monitoring system is established for targeted behaviors, interventions and medication effectiveness and side effects. An interdisciplinary assessment is completed on resident admitted with			

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	155278	A. BUILDING 00 B. WING	02/14/2014

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	new antipsychotic medication." The 2014 Lippincott's Nursing Drug Guide, copyright 2014, the adverse effects for Ativan include, but are not limited to, "transient, mild drowsiness initially, sedation, depression, lethargy, apathy, fatigue, light-headedness, disorientation, anger, hostility, restlessness, confusion, headache, mild paradox excitatory reactions during first week of treatment, dry mouth, nausea, drug dependence with withdraw syndrome when drug is discontinued; more common with abrupt discontinuation of higher dosage used for longer than 4 months." 3. On 2/12/2014 the clinical record was reviewed for Resident #44. Diagnosis included but were not limited to, hypertension, weight loss, disorders of bone and cartilage, anxiety, chronic pain, dementia, atrial fibrillation. Review of the medication orders included Remeron 30 mg for generalized anxiety disorder and Ativan 0.25 mg three times daily for generalized anxiety disorder. On 2/12/14 at 3:21 p.m., the unit			

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	155278	A. BUILDING 00 B. WING	02/14/2014

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	manager provided Resident #44's care plan. There was no care plan for anxiety. The facilities undated "DRUG DOSAGE REDUCTION LOG ANTIANXIETY' provided by ADON on 2/13/14 at 9:39 a.m., indicated Resident #44's Ativan was decreased from 1 mg at bedtime to 0.25 three times daily on 12/24/13. The Remeron was increased on 12/24/2013 from 7.5 mg to 15 mg at bedtime. Remeron was increased from 15 mg to 30 mg at bedtime. Nurses notes dated 2/4/2013 at 11:04 p.m., indicated "Res (resident) seen by vericare on 1/30 with recommendation received (received) to increase remeron (Remeron) to 30mg qhs (at bedtime) for tearfulness and "sad mood" noted at time of assessment...." Copies of the medication administration record was provided by LPN #1 on 2/13/2014 at 11:00 a.m. The electronic medication administration record had no side effects listed for antianxiety medication there was no sign off for signs or symptoms for use of antianxiety medication.			

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	The 2014 Lippincott's Nursing Drug Guide, copyright 2014, the adverse effects for Ativan included but are not limited to, transient, mild drowsiness initially, sedation, depression, lethargy, apathy, fatigue, light-headedness, disorientation, anger, hostility, restlessness, confusion, headache, mild paradoxal excitatory reactions during first week of treatment, dry mouth, nausea, drug dependence with withdraw syndrome when drug is discontinued; more common with abrupt discontinuation of higher dosage used for longer than 4 months. The facilities current policy "Behavior Management Guideline," dated 2013, indicated..."Other known side effects of these drugs that must be monitored include:..Monitoring Compliance IPOC or care plan is developed for residents exhibiting negative behavior or with antipsychotic drug uses. A monitoring system is established for targeted behaviors, interventions and medication effectiveness and side effects. An interdisciplinary assessment is completed on resident admitted with new antipsychotic medication."			

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	On 2/13/2014 at 1:50 p.m., an interview with LPN #1 (Licensed Practical Nurse) indicated that she does monitor for side effects like lethargy, or sedation but there was no where to document that there are no signs or symptoms for use of Ativan. 3.1-48(a)(3)			
F000332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5 percent. Three (3) medication errors were observed during 40 opportunities for error in	F000332	It shall be the policy of Golden Living (of Bloomington) to ensure the Facility is free of medication errors of five (5) percent or greater. A) LPN #3 was inserviced on the proper administration of an inhaler	03/16/2014

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	medication administration. This resulted in a medication error rate of 7.5%. (Resident #13, Resident #30) (LPN #3) Findings include: 1. On 2/14/14 at 8:44 a.m., observed LPN #3 to not give Resident #30 the prescribed oxybutin ER (Treats an overactive bladder) 5 mg (milligrams) during medication administration. LPN #3 indicated, "Oh I got to get it from down there, [LPN#3 pointed down the hall] it's not here." LPN #3 not observed to go get the medication. LPN#3 observed to enter Resident #30's room to administer pills without the oxybutin. LPN#3 was observed to hand Resident #30 the Advair diskus inhaler (for the treatment of asthma) and was not observed to have Resident #30 rinse mouth with water after using the inhaler. On 2/14/14 at 2:54 p.m., review of progress notes, dated 2/14/14, received from the Unit Manager for hall 1 indicated, " eMAR-Medication Administration Note [electronic charting system] ... Not in stock, ordered from pharmacy. Daughter and Dr. _____ [Name] notified. .... Received new order from Dr.		including the rinsing of the mouth after each administration. All licensed nurses will be inserviced (3/13/14) regarding proper inhaler administration including rinsing of the mouth. The DCE and Weekend RN Supervisor will audit inhaler administration 5x's/week (and weekend) for one (1) week, 4x's/week (and weekend) for one (1) week, 3x's/week (and weekend) for one (1) week. Instructions on the eMAR will be revised to include rinsing of mouth after each inhaler administration. The Unit Managers will ensure all current patients and new admissions inhalers have the requisite instructions included on the eMAR. All audits will be turned in to the DNS for review. The QAPI Committee will review the audit monthly for 3 months to determine discontinuation or the need for further review. B) The MD was notified of the unavailability of the medication for resident #30. A new order was received to hold the medication on the day of reference. All licensed Nurses will be inserviced (March 13, 2014) regarding the procedure for re-ordering medications from the pharmacy. The Facility pharmacy provider will be notified if a medication is not available and that medication will be delivered by the backup pharmacy. A medication "Unavailable" form will	

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	155278	A. BUILDING 00 B. WING	02/14/2014

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	_____[Name] hold oxybutin today and resume tomorrow." On 2/14/14 at 2:54 p.m., review of physician's order, dated 2/14/14, indicated "oxybutin Chloride (5mg) (oxybutin Chloride) Tablet Extended Release 24 hour 5 mg By mouth. ... SYMPTOMS INVOLVING URINARY SYSTEM ..." 2. On 2/14/14 at 8:54 a.m., observed LPN #3 to administer Advair inhaler to Resident #13, without having the resident's rinse their mouth after administering that medication. On 2/14/14 at 11:16 a.m., interview with LPN#3 indicated, when asked how should Advair inhaler be administered " Inhale one puff and then rinse mouth with water and spit out." When asked if that was done for Resident #13, and Resident #30 LPN #3 indicated, "No, I did not." On 2/14/14 at 3:09 p.m., review of the facilities current procedure labeled " Oral Inhalation Administration " the policy was revised on November 2011. The policy was received from the ADON (Assistant Director of Nursing) 2/14/14, the policy indicated, " ... Q. For steroid inhalers, provide resident		be completed and turned in to the DNS. The forms will be discussed with the pharmacy provider General Manager. The QAPI Committee will review the medication "Unavailable" results to determine the need for further monitoring or discontinuation.	

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	155278	A. BUILDING 00 B. WING	02/14/2014

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	with cup of water and instruct him/her to rinse mouth and spit water back into cup." On 2/14/14 review of Advair diskus https://www.advair.com Administration Guidelines revised on 9/2011 indicated "... 2 DOSAGE AND ADMINISTRATION ADVAIR DISKUS should be administered twice daily every day by the orally inhaled route only. After inhalation, the patient should rinse the mouth with water without swallowing." 3.1-25 (b)(9)			
F000371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions 1. Based on record review, observation, and interview, the facility failed to provide safe food handling technique by not ensuring the staff used the proper sanitizing solution while processing meals.	F000371	There were no residents directly affected by this practice. The sanitizing solution was immediately replaced with the proper concentrations sanitizing solution on 02/10/14. Dietary staff will be inserviced (by 03/13/14) on proper sanitizing	03/16/2014

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	This deficient practice had the potential to effected 134 out of 134 residents served meals. (Staff DA #1, DM) 2). Based on record review, observation, and interview, the facility failed to provide safe food handling technique by not ensuring the staff used dry equipment when processing puree foods. This deficient practice had the potential to effected 11 out of 11 residents served puree meals. (DA #1, DM) 3). Based on observation and record review, the facility failed to ensure staff used proper handwashing in the passing of drinks, in that the staff was observed not to wash their hands as indicated by facility policy. This deficient practice had the potential to affect 14 out of 14 residents served in Horizons dining room. (Unit Coordinator #1) Findings include: 1. Observation on 2/10/2014 at 11:30 a.m., kitchen sanitizing bucket #1 and bucket #2 sitting on a kitchen cart. Sanitizing bucket #1 and bucket #2 contained dark gray dirty water. Staff DA (Dietary Aide)		solution concentration, when to change solution, glove use, and sanitizing surfaces. Dietary staff will be inserviced (by 03/13/14) on pureed procedures and using clean, dry equipment during food preparation. The UC #1 will be inserviced (by 03/16/14) on proper hand hygiene procedure during meal service. To ensure the practice does not reoccur, the Dining Services Director, Registered Dietitian (or designee) will inspect and monitor dining staff and kitchen for proper glove use, sanitizing solution, and food preparation with food processor five 5x's/week for four (4) weeks and then three 3x's/week for an additional eight (8) weeks. If compliance is achieved, inspection and monitoring will revert to routine weekly inspections.	

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	#1 placed a gloved hand in bucket #2 and removed a cleaning cloth and wiped off a counter, returned the cloth to the bucket #2 and wiped off another counter. Observation on 2/10/2014 at 11:35 a.m., DM (Dietary Manager) tested bucket #1 and bucket #2 of sanitizing water. Bucket #1 and bucket #2 test stripe read 100, which indicated the water in bucket #1 and bucket #2 were not at the correct concentration to sanitize. Observation on 2/10/2014 at 12:00 a.m., DM tested bucket #1 and bucket #2 of sanitizing water. Bucket #1 and bucket #2 test strip read 200, which indicated the water in the bucket #1 and bucket #2 were at the correct concentration to sanitize. Interview on 2/10/14/ at 11:37 a.m., with the DM indicated test stripe should be 200 to sanitize, we change the wash bucket three times a day after each meal. Interview on 12/14/14 at 10:45 a.m., with DM indicated the sanitizing solution is premixed with water and sanitizing solution at the dispenser and the sanitizing buckets are filled			

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	at the dispenser. Policy review on 2/14/14 at 2:25 p.m., "Cleaning Kitchen Areas", not dated, indicated, " change sanitizing solution: 1. After cleaning prep or work areas that were contaminated with meat or protein items. 2. As it becomes cloudy or dirty. 3. At the beginning of each shift." 2. Observation on 2/10/14 at 11:25 a.m., DA# 1 placed cooked broccoli into a wet food processor bowl, then place a wet food processor bowl cover over the bowl and started to puree the broccoli. DA #1 then placed the puree broccoli in a clean dry container. During an interview at 11:27 a.m., DA#1 indicated the food processor bowl should be completely dry before placing the broccoli in the bowl. Da #1 indicated the bowl used was not dry. 3. During dining observation on 2/10/14 at 12:00 p.m., Unit Coordinator #1 was observed passing drinks in the Horizon's dining room. Unit Coordinator #1 poured 5 drinks into cups and			

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	passed drinks to Resident #90 and Resident #111. She went back to the tray and poured 2 more drinks into cups. She then went to the cupboard above the sink to find more cups. Kitchen staff arrived and was told by unit coordinator that they needed more cups and milk in the dining room. Unit coordinator then went to the refrigerator, opened up the door and looked for something. She shut the door and went back to the cups. Unit Coordinator was observed not to wash her hands or use hand sanitizer. Unit Coordinator was observed to serve Resident #133, Resident #34 and Resident #146 drinks. She went back to the tray of cups and poured more drinks and then proceeded to open the cupboard under the sink. She went back to the cups and poured 4 more drinks for residents. Unit coordinator was observed not to wash her hands or use hand sanitizer. After pouring drinks and serving resident's their drinks in the Horizon's dining room, Unit Coordinator pushed the tray with drinks and cups into a smaller dining area. She was not observed to wash or sanitize her hands. On 2/12/14 at 2:10 p.m., the Director			

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	of Nursing (DON) provided the facility's "Hand Cleaner, Antiseptic" policy, dated 2006, and indicated the policy is currently used by the facility. Review of the policy "Hand Cleaner, Antiseptic" indicated, "... Purpose: To cleanse the hands between resident contacts...Equipment: Antiseptic cleanser such as alcohol gel or solution in pump container or "squeeze" bottle per facility procedure...Procedure...7. Hands should be washed with soap and water after 10-15 applications of hand cleaner, or as directed by manufacturer." On 2/12/14 at 2:10 p.m., the Director of Nursing (DON) provided the facility's "Hand Washing" policy, dated 2006, and indicated the policy is currently used by the facility. Review of policy "Hand Washing" indicated, "Basic Responsibility-All Nursing Staff...Purpose: Medical asepsis to control infection...General Instructions: Wash hands before and after resident contact..." 3.1-21(i)(3)			

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F000412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. Based on observation, interview and record review, the facility failed to ensure a resident received dental care by a Dentist for 1 of 1 residents reviewed for dental status in the stage 2 sample. (Resident #3) Finding includes: On 2/13/2014 at 11:40 a.m., the clinical record was reviewed for Resident #3. Diagnosis included but were not limited to, hypertension, anemia, urinary tract infections, hyperpotassemia, chronic kidney disease stage IV, and depressive	F000412	There were no residents directly affected by this practice. The sanitizing solution was immediately replaced with the proper concentrations sanitizing solution on 02/10/14. Dietary staff will be inserviced (by 03/13/14) on proper sanitizing solution concentration, when to change solution, glove use, and sanitizing surfaces. Dietary staff will be inserviced (by 03/13/14) on pureed procedures and using clean, dry equipment during food preparation. The UC #1 will be inserviced (by 03/16/14) on proper hand hygiene procedure during meal service. To ensure the practice does not reoccur, the Dining Services Director, Registered Dietitian (or designee)	03/16/2014

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	disorder. The quarterly MDS (Minimum Data Set) assessment, completed on 11/22/2013, indicated the BIMS (Brief Interview of the Mental Status) indicated Resident #3 score was an 11 out of a score of 0-15. This score indicated the resident was interviewable. The annual MDS (Minimum Data Set) dental assessment, completed on 8/27/2013, indicated no natural teeth or tooth fragments. No obvious or likely cavity or broken natural teeth. Review of Resident #3's chart indicated there was no consult from Dentist in chart. The facilities "QUARTERLY INTERDISCIPLINARY RESIDENT REVIEW" completed on 2/5/14 at 2:50 p.m., for Resident #3 indicated.... "CONDITION OF TEETH/ORAL CAVITY....natural teeth, gum margins intact, mucous membrane moist...Summary/Outcome/Recommendations...." This review indicated no referral for dental consult. On 2/13/2014 at 2:45 p.m., an		will inspect and monitor dining staff and kitchen for proper glove use, sanitizing solution, and food preparation with food processor five 5x's/week for four (4) weeks and then three 3x's/week for an additional eight (8) weeks. If compliance is achieved, inspection and monitoring will revert to routine weekly inspections.	

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	observation of Resident #3's mouth with LPN #2 indicated the tooth on the upper left in the back had a large metal filling, the tooth around the filling is broken. In the right upper front Resident #3's tooth is broken off, LPN #2 asked Resident #3 if it was bothering her. Resident #3 indicated it hurts her tongue when her tongue touches it because it's broken off. On 2/13/2014 at 3:15 p.m., an interview with unit manager for the Horizons unit indicated the son takes Resident #3 to the dentist. She indicated they call the dentist office and they refused to send over Resident #3's records. She indicated the son would allow her to be seen by the dentist here tomorrow, as long as there was no out of pocket expense. 3.1-24(a)(1)			

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	155278	A. BUILDING 00 B. WING	02/14/2014

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F000425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, interview and record review, the facility failed to ensure that the prescribed medication was available for administration when it is due. This deficient practice had the potential to affect 1 of 4 residents observed for medication administration on hall #1. (Resident #30) (LPN #3) Findings include: On 2/14/14 at 8:44 a.m., observed LPN#3 to not give Resident #30 the prescribed oxybutin ER (medication for overactive bladder) 5 mg	F000425	It shall be the policy of Golden Living (of Bloomington) to provide routine drugs and biological to each patient as required and ordered. The MD was notified of the unavailability of the medication for resident #30. A new order was received to hold the medication on the day of reference. All licensed Nurses will be inserviced on March 13th regarding the procedure for re-ordering medications from the pharmacy. The Facility pharmacy provider will be notified if a medication is not available and that medication will be delivered by the backup pharmacy. A medication "Unavailable" form will	03/16/2014

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	(milligrams) during medication administration. LPN #3 indicated, "It is not available. Oh I got to get it from down there, [LPN#3 pointed down the hall] it's not here." LPN #3 was not observed to go get the medication. LPN#3 was observed to enter Resident #30's room to administer pills without the oxybutin ER. On 2/14/14 at 2:00 p.m., LPN #3 indicated, "I have not given Resident #30 [gender] oxybutin." When asked what is protocol when medication is not available for residents. LPN #3 indicated, " I notify the physician, the family, and then write a incident report." On 2/14/14 at 2:54 p.m., review of progress notes, dated 2/14/14, received from the Unit Manager for hall 1 indicated, " eMAR-Medication Administration Note [electronic charting system] ... Not in stock, ordered from pharmacy [pharmacy]. Daughter AND [and] Dr. _____ [Name] notified. .... Received new order from Dr. _____[Name] hold oxybutin today and resume tomorrow." On 2/14/14 at 2:54 p.m., review of the physician's order, dated 2/14/14,		be completed and turned in to the DNS. The forms will be discussed with the pharmacy provider General Manager. The QAPI Committee will review the medication "Unavailable" results to determine the need for further monitoring or discontinuation	

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	indicated "Oxybutin Chloride (5 mg) (Oxybutin Chloride) Tablet Extended Release 24 hour 5 mg By mouth. ... SYMPTOMS INVOLVING URINARY SYSTEM ...." 3.1-25 (g)(3)			

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F000431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to ensure that all medications in the EDK (emergency drug kit) were	F000431	It shall be the policy of Golden Living (of Bloomington) to store and secure all drugs and biologicals in accordance with all State and Federal rules,	03/16/2014

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	locked in accordance with State, Federal law and the facilities current policy. This deficient practice affected 4 out of 7 EDK's observed in the medication storage room on hall #2. Findings include: On 2/14/14 at 11:35 a.m., observation with Unit Manager for hall #2 present EDK's (emergency drug kit) were unlocked with broken seals, and inside the kit were medications unlocked with broken seals. The medications included: Lortab (pain medication), Lasix (water pill), Zithromax (antibiotic), Levaquin (antibiotic), Cipro (antibiotic), Fentanyl patches (pain medication), Dilantin (seizure medication), and Norco (pain medication). There were 4 EDK's observed to have broken seals on the outside of the kit, and the medication inside had broken seals (a broken seal indicates that it has been opened). The EDK removal slips in the open kits indicated the last person to place a removal slip was LPN #1, LPN#4, RN #2, and LPN #5. The Unit Manager for hall #2 indicated, "I am not sure if those EDK's have to		regulations, and laws pertaining to the same. The Unit Manager secured all EDKS's after the count was deemed correct when counted by both the Unit Manager and the Surveyor. All licensed Nurses will be inserviced (March 13, 2014) on the Facility policy for securing the EDK after drug removal. The Station Two (2) Unit Manager - or designee - and the Weekend RN Supervisor will audit daily to ensure the EDK is secured properly x 4 weeks, then 3x's/week x 4/weeks and then 1x's/week x 4/weeks. The audits will be provided to the DNS for review. All audit results will be reviewed at the monthly QAPI meeting to determine the need for further monitoring or discontinuation	

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	155278	A. BUILDING 00 B. WING	02/14/2014

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	be locked. I know that the narc [narcotic] EDK's do but I would have to check on the other EDK's that have antibiotics and injectable medication." The Unit Manager was observed to place seals on the EDK's. On 2/14/14 at 12:00 p.m., Unit Manager for hall #2 indicated, "The pharmacy tech was here also and could have been the last one in the EDK's." When asked what the facility protocol was for the removal of medication from the EDK the Unit Manager indicated, " To record what was taken on the slip and place in the EDK so that pharmacy can replace medication that was removed, put a seal on the container and seal the EDK for narcotics, but I would have to check about the other EDK boxes." On 2/14/14 at 1:41 p.m., review of the facilities current policy and procedure labeled " Emergence Pharmacy Service and Emergency Kits," dated 05/12, and was received from the DON (Director of Nursing) at this time. The policy indicated, " F. The emergency supply is maintained at [a designated area], along with a list of supply contents and expiration dates as follows:			

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	155278	A. BUILDING 00 B. WING	02/14/2014

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	1). Emergency non-parenteral medications are kept [at designated units/with other emergency medications] in [a sealed, portable container/locked drawer/cabinet]. 2). Antibiotic starter doses are kept [at designated units/with other emergency medications] in [a sealed, portable container/locked drawer/cabinet]. ... 4). Emergency controlled substances are kept [at designated units/with other emergency medications] in [a sealed,portable container/locked drawer/cabinet]. ... H. ... 3). The nurse records the mediation use from the emergency kit on the [medication order/use form] and [call the pharmacy for replacement of the kit/dose and/or flag the kit with a color-coded lock to indicate need for replacement of kit/dose] as soon as possible after the medication has been administered...." 3.1-25(m)			

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F000441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview and record review, the facility failed to	F000441	It shall be the policy of Golden Living (of Bloomington) to	03/16/2014

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	ensure proper handwashing by staff during a dressing change. (RN #1, Resident #162) Findings include: On 2/14/14 at 2:00 p.m., an observation of RN #1 changing a dressing on Resident #162's left lower leg. RN #1 didn't wash her hands prior to removing old dressing, applied gloves and removed old dressing. She then cleansed the wound with normal saline and opened the gauze package and applied the gauze, she then covered the gauze with stretch roll and applied tape. She then removed gloves and washed her hands for 10 seconds. At that time, an interview with RN #1 indicated the proper amount of time for handwashing was 20-30 seconds. On 2/14/14 at 3:20 p.m., the facilities current dressing change policy dated 2006. The policy indicated... Procedure.... 5. Put on first pair of disposable gloves 6. Remove soiled dressing and discard in plastic bag.... 8. Put on second pair of disposable gloves.		practice an Infection Control Program that ensures a safe, sanitary, and comfortable living environment while preventing the development, transmission of disease and infection. RN #1 was individually inserviced by the DCE regarding proper dressing change and handwashing techniques. All licensed Nurses will be inserviced (March 13, 2014) on proper dressing and handwashing techniques. DEC (or designee) will observe and audit daily dressing change (Weekend RN Supervisor Saturday/Sunday) x 4/weeks, then 3x's/week x 4/weeks the 1x's/week x4/weeks. Audits will be turned in to the DNS for review. The audit results will be reviewed by QAPI x 3 months to determine if further monitoring is necessary or discontinued.	

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	3.1-18(l)			